**Anthony C. Zwaan, MD**
***Family Medicine***
**19 Hampton Road, Suite One, Exeter, NH 03833**
**Tel. 603-773-2225 Fax 603-658-3105**

# AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION (MEDICAL RECORDS)

Patient's Name:________________________________________Date of Birth:_______________

Phone #:_________________________Alternate #:_______________________

RELEASE RECORDS FROM: *(complete below and mail this form to the place you have listed)*

_____________________________________________________

_____________________________________________________

_____________________________________________________

You are authorized and requested to release protected health information about the above named patient's care or copies of medical records in your possession.

□*: All health care information and records. (General and Complete Release) *

□: Health care information relating to the following treatment, condition or dates. (Limited Release)

________________________________________________________________________________

I authorize the release of information regarding treatment of mental health conditions, drug or alcohol use, and treatment or testing for sexually transmitted diseases (including HIV/AIDS testing whether negative or positive).

□ **Yes *** □ **No**

*(*Recommended; If you do not select this, release of information may be substantially limited.)*

SEND RECORDS TO:

**Anthony C. Zwaan, MD**
***Family Medicine***
**19 Hampton Road, Suite One**
**Exeter, NH 03833**

♦ I understand this authorization may be revoked in writing at any time unless that information has already been disclosed prior to the date of revocation.

Signature:_____________________________________________Date Signed:___________________________
(Patient, Parent or Guardian) (Expires 6 month/180 days from this date)